

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1610

320.

File No. _____
Registered No. _____
Ward _____

1. PLACE OF DEATH

55 County Lawrence
1 Township Aurora
4 City Aurora (No. 823 Porter ave)

Registration District No. 462
Primary Registration District No. 4280

2. FULL NAME

Mary E. Nivens
(a) Residence. No. 823 Porter St., _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Nivens

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 7-1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
56 3 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) 235
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Barry Co
(STATE OR COUNTRY) Mo

10. NAME OF FATHER John Hilton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Barry Co
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Nancy J. Thomas
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo

14. INFORMANT Frank Nivens
(Address) Aurora Mo

15. FILED _____, 19 _____ W. L. Sherry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16 1932

17. HEREBY CERTIFY, That I attended deceased from Nov., 1931, to Jan 16, 1932, that I last saw her alive on Jan 14, 1932, and that death occurred, on the date stated above, at 6 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral edema
8 30 A (duration) yrs. 3 mos. ds.
CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Thomas D. Miller M. D.
, 19 _____ (Address) Aurora Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple park DATE OF BURIAL 1/20/32
20. UNDERTAKER King Funeral Home ADDRESS Aurora Mo

FILED FEB 24 1932

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

